DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To:	All Providers Managed Care Plans CSO Administrators	**Memorandum No: 05-94 MAA** **Issued:** November 1, 2005
From:	Douglas Porter, Assistant Secretary Medical Assistance Administration	**For More Information, call:** 1-800-562-3022

Subject: **Reinstatement of Children's Health Program;**
Changes to Medical Identification (ID) Card; and
Clarification of Payment Responsibility for Managed Care Copayment and Deductibles for Qualified Medicare Beneficiaries

Effective for dates of service on and after January 1, 2006, the Medical Assistance Administration (MAA) is:

1. Reinstating the Children's Health Program (CHP) – this memo clarifies who is eligible and the scope of coverage;

2. Changing the Health Insurance Claim (HIC) Number on the Medical Identification (ID) Card.'

3. This memo also clarifies the state's responsibility for managed care copayments and deductibles for Qualified Medicare Beneficiaries (QMB).

1. The Children's Health Program

[Refer to WAC 388-505-0210]

Effective January 1, 2006, the Children's Health Program (CHP) will be reinstated. This program addresses health concerns of children who:

- Are 17 years of age or younger;
- Are not eligible for Medicaid because of their citizenship status; and
- Have a family income at or below 100 percent of the federal poverty level (FPL).

What You Need to Know to Provide Services

Children eligible for CHP can receive full-scope, categorically needy (CN), fee-for-service medical benefits. CHP clients are issued a Medical ID card that includes the following information:

- F08 in form field 4 in the upper right-hand corner; and
- CNP in form field 19 in the lower right-hand corner.

2. The Entire Health Insurance Claim (HIC) Number Will No Longer Be Displayed on the Medical Identification (ID) Card

Why is the change necessary and what will it look like?

- RCW 74.09.037 allows **only** the last four digits of a Social Security number to be used as an identifier.

- The HIC number displayed on the Medical ID Card will consist of the last four digits of the Medicare claim number (Social Security number) plus a letter suffix (e.g., 5555A) This is located in **form field 17** in the lower left corner of the ID card.

What does this mean to the provider?

When billing for services provided to Medicare clients, you must use the complete HIC number. To obtain a client's complete HIC number:

- Ask the client to present his/her Medicare ID Card;
- Use the eligibility capability online at https://wamedweb.acs-inc.com/wa/general/home.do; or
- Call 1-800-562-0322 and request the client's Medicare HIC Number.

3. Clarification of the State's Responsibility for Managed Care Copayments and Deductibles for Qualified Medicare Beneficiaries (QMB) Clients.

MAA changed the last sentence under the heading, "Medicare Managed Care (Medicare Part C)" on page E.4 of the General Information Booklet, dated July 2005, **as follows:**

> "While states are not required to pay managed care premiums, they are required to pay managed care copayments, coinsurance, and deductibles for QMB clients up to Medicare's or Medicaid's allowable (whichever is less)."

Billing Instruction Replacement Pages

Attached are updated replacement pages D.3/D.4; D.7/D.8; and E.1 – E.6 for MAA's current *General Information Booklet.*

How do I access WaMedWeb?

http://wamedweb.acs-inc.com

How can I get MAA's provider issuances?

To obtain DSHS/HRSA provider numbered memoranda and billing instruction, go to the DSHS/HRSA website at http://hrsa.dshs.wa.gov (click ***the Billing Instructions and Numbered Memorandum*** link). These may be downloaded and printed.

Key to the Medical ID Card

Field Description

1. Address of CSO/HCS/MEDS.
2. Date eligibility begins.
3. Date eligibility ends.
4. Medical coverage group.*

Patient Identification Code (PIC) Segments Are:

5. First and middle initials *(or a dash (-) if no middle initial)*.
6. Six-digit birth date, consisting of numerals only (*MMDDYY*).
7. First five letters of the last name (*and spaces if the name is fewer than five letters*).
8. Tiebreaker (*an alpha or numeric character*).

Medical Coverage Information

9. **Insurance carrier code** - A four-character alphanumeric code *(insurance carrier code)* in this area indicates the private insurance plan information.*
10. **Medicare** - *Xs* indicate the client has Medicare coverage.
11. **HMO** *(Health Maintenance Organization)* – Alpha code indicates enrollment in an MAA managed care plan. This area may also contain the identifier PCCM *(primary care case manager)*. The following ACES medical coverage groups, if not otherwise exempt, are required to enroll in MAA managed care: F01, F02, F03, F04, F05, F06, H01 and P02.* SCHIP enrollment is limited to F07. GA-U clients in King or Pierce counties, if not exempt are required to be enrolled in an MAA managed care plan: G01. Clients in the following ACES medical coverage groups can voluntarily enroll in MMIP or WMIP: C01, G02, G03, K01, L01, L02, S01, and S02.
12. **Detox** - *Xs* indicate eligibility for a 3-day alcohol or a 5-day drug detoxification program.
13. **Restriction** - *Xs* indicate the client is on restriction or review due to over utilization or inappropriate utilization of medical services. The client is assigned to 1 physician, 1 pharmacist, and/or 1 hospital for nonemergent care. The words “client on review” will also be in field 20.*
14. **Hospice** - *Xs* indicate the client has elected hospice care.*
15. **DD client** - *Xs* indicate this person is a client of the DSHS Division of Developmental Disabilities.
16. **Other** - This area is not in use.
17. **Health Insurance Claim (HIC)** number shown here indicates that the client is on Medicare.
18. **Name and address** of client, head of household or guardian.
19. **Medical program identifier** and medical program name.*
20. **Other messages** *(e.g., client on review, delayed certification, emergency hospital only)*.*
21. **Telephone number** and name of PCCM or MAA managed care plan.*
22. **Local field office** *(3 digits)* and ACES assistance unit # *(9 digits)*.
23. **Internal control numbers** for DSHS use only.
24. **Client’s signature** - May be used to verify identity of client.
25. **Client’s primary language**.

***See following pages for further details about this field.**

Field 4 – Medical Coverage Group

The codes below are the medical coverage groups found in field 4. These codes identify the type of medical assistance benefits the patient is eligible to receive.

By identifying the client's medical coverage group, the provider can determine the need for additional services such as pregnancy-related First Steps services or the provider can determine if the patient is potentially an enrollee of an MAA managed care plan.

Medical Coverage Group Codes	Medical Coverage Group Definitions
C01, C95, and C99	Hospice and waiver and Community Based Programs such as COPES, Basic, Basic+, CORE, and Community Protection
D01 and D02	Foster Care and Adoption Support
F01, F02, F03, F04	Family Medical
F05, F06, F08	Children's Medical
F07	State Children's Health Insurance Program (SCHIP)
G01 and G02	General Assistance
G03, G95, and G99 facility (ALF)	Medical Assistance for a resident of Alternate Living Facility (ALF)
H01	Legal guardian (children)
I01	Institution for the Mentally Diseased (IMD)
K01,K03,K95, and K99	Long-Term Care – F4amilies
L01, L02, L04, L95, and L99	Long-Term Care – Aged, Blind, Disabled
M99	Psychiatrically Indigent Inpatient
P02, P04, and P99	Pregnancy related
P05	Family Planning Only
P06	TAKE CHARGE
R01, R02, and R03	Refugee
S01, S02, S95, and S99	Aged, Blind, or Disabled (SSI)
S03, S04, S05, and S06	Medicare cost savings
S08	Healthcare for Workers with Disabilities (HWD)
W01, W02, and W03	ADATSA
F09 and S07	Alien Emergency Medical

Services provided by the following providers are **not** subject to restriction by the PRR program:

Dentists
Drug Treatment Facilities
Emergency Medical Services
Family Planning Agencies
Home Health Agencies
Medical Transportation Services
Mental Health Facilities
Optometrists
Other Medical Providers
(e.g., Durable Medical Equipment)

If you have questions about the PRR program or wish to report a client for utilization review call (360) 725-1780.

Field 14 - Hospice

Hospice Services are available to clients in the Categorically Needy Program (CNP), Medically Needy Program (MNP), and SCHIP.

Terminally ill clients with a life expectancy of 6 months or less may choose to enroll in the Hospice benefit program. When enrolled in the Hospice program, clients ***waive*** services outside the Hospice program that are directly related to their terminal illness. All services related to their terminal illness are coordinated and provided by the designated hospice agency and attending physician ***only***. Other providers **will not be reimbursed** by MAA for services related to the terminal illness. For further information, refer to MAA's *Hospice Services Billing Instructions*.

Only services **not** related to the terminal illness/hospice diagnosis may be provided to clients on a fee-for-service basis if covered under the client's MAA program. For information about an MAA managed care plan client enrolled in a Hospice program, the provider should contact the client's plan for further information.

Field 19 - Medical Program Identifier and Medical Program Name

Medical Program Identifier (How the program appears on the ID card)	**Full Medical Program Name**
CNP	Categorically Needy Program
CNP **CHIP**	State Children's Health Insurance Program
CNP	Children's Health Program
CNP **Emergency Medical Only**	CNP – Alien Emergency Medical
CNP - QMB	CN-Qualified Medicare Beneficiary
Detox Only	Detox
Family Planning Only	Family Planning Program
GA-U **No Out of State Care**	General Assistance - Unemployable
General Assistance	ADATSA, ADATSA Medical Only
LCP-MNP	Limited Casualty Program - Medically Needy Program
LCP-MNP **Emergency Medical Only**	Medically Needy Program – Alien Emergency Medical
MIP - Emergency Hospital Only **No Out-of-State Care**	Psychiatric Indigent Inpatient (PII) program
QMB – Medicare Only	Qualified Medicare Beneficiary - Medicare Only
TAKE CHARGE Family Planning	TAKE CHARGE

☞ **Note:** See Section E *Program Descriptions* for further information on each program.

Medical Program Descriptions

Categorically Needy Program (CNP)

CNP is a Medicaid program in which eligible individuals have full-scope medical/dental coverage (except Orthodontics). Eligible individuals include:

- **Aged -** Individuals 65 years old or older.
- **Blind -** Individuals who meet the social security requirement for blindness.
- **Children under age 19**.
- **Disabled -** Individuals who meet the social security requirement for disability.
- **Families with dependent children.**
- **Newborns -** Automatically eligible for CNP for 12 months if their mother received medical benefits at the time of the child's birth.
- **Pregnant women -** Eligible at any time during pregnancy.

CNP - Emergency Medical Only **[Refer to WAC 388-438-0110]**

This is a Medicaid program for persons who do not meet citizenship requirements but meet all other eligibility requirements for CNP. The scope of care is limited to services needed as a result of an emergency medical condition.

CNP - Qualified Medicare Beneficiaries (CNP-QMB)

This is a Medicaid program for certain low-income individuals who are eligible for Medicare.

- If a service is **covered by Medicare and Medical Assistance**, the Medical Assistance Administration (MAA) pays the deductible and coinsurance up to Medicare's or MAA's allowed amount, whichever is less.

- MAA also reimburses for services that are **not covered by Medicare but are covered by Medical Assistance** under the CNP program.

- If the service is **covered only by Medicare and not Medical Assistance**, MAA pays the deductible and coinsurance up to Medicare's allowed amount.

Children's Health Program (CHP)

[Refer to WAC 388-505-0210]
(Not to be confused with the State Children's Health Insurance Program – SCHIP)

The Children's Health Program (CHP) addresses health concerns of children who:

- Are 17 years of age or younger;
- Are not eligible for Medicaid because of their citizenship status; and
- Have a family income at or below 100 percent of the federal poverty level (FPL).

State Children's Health Insurance Program (SCHIP)

[Refer to Chapter 388-542 WAC]

- SCHIP is a federal/state program that covers medical services for children under age 19 in families whose income is too high to be eligible for Medicaid, but is within 200 to 250% of the Federal Poverty Level. Children who have other medical coverage at the time of application are not eligible for SCHIP.

- SCHIP has the same scope of coverage as the Categorically Needy Program (CNP).

  Premiums

  SCHIP client premiums are paid by the family to DSHS. There is a grace period for nonpayment, but clients who do not pay the premiums for three months are disenrolled from SCHIP.

  Clients must send payments for their monthly premium to:

  DSHS Finance Division
  PO Box 9501,
  Olympia, WA 98507-9501.

  ☞ **Note:** American Indian/Alaska Native (AI/AN) clients are exempt from paying client premiums.

Family Planning Only [Refer to Chapter 388-532 WAC]

This is a state-funded program providing an additional 10 months of family planning services to eligible women who have just ended a pregnancy or completed a delivery. This benefit follows the 60-day, post-pregnancy coverage for women who receive medical assistance benefits during the pregnancy. The program's coverage is strictly limited to family planning services. Visit MAA's Family Planning web site at: http://maa.dshs.wa.gov/familyplan .

General Assistance - Unemployable (GA-U) and Detox

GA-U and Detox are state-funded programs that provide some medical and emergent dental services for general assistance-unemployable clients. These programs allow a limited scope of medical care within Washington State and border areas; **out-of-state care is not covered**.

Refer to MAA's specific program billing instructions for limitations (see *Important Contacts* section). Border areas are listed on page A.20 of this General Information Booklet.

Limited Casualty Program – Medically Needy Program (LCP-MNP)

This is a Medicaid program that provides a limited scope of medical care for individuals who do not meet the eligibility income/resource criteria for income assistance. A Medical ID card is issued to the client when medical bills and emergency medical expenses meet the spenddown. Spenddown is calculated based on income and resources.

LCP-MNP - Emergency Medical Only

This is a Medicaid program for persons who are eligible for MNP but do not meet citizenship requirements. The scope of care is limited to services relating to an emergency medical condition.

Medicare Cost Savings Programs

Qualified Medicare Beneficiaries (QMB - Medicare Only)

This is a Medicaid program for certain low-income individuals who are also eligible for Medicare. MAA pays Part A and Part B Medicare premiums for QMB-eligible clients. The reimbursement criteria for this program are as follows:

- If the service is **covered by Medicare and Medical Assistance**, MAA pays only

the deductible and coinsurance, up to the Medicare or MAA allowed amount, whichever is less.

- If the service is **covered only by Medicare and not Medical Assistance**, MAA pays only the deductible and coinsurance up to Medicare's allowed amount.

- If the services are **not covered or are denied by Medicare**, MAA does not make any reimbursement.

Specified Low-Income Medicare Beneficiary (SLMB)

This is an MAA program for certain low income individuals who are also eligible for Medicare and meet the income levels (100-119% FPL). Under this program, MAA pays Medicare Part B premiums. Clients can be dual-eligible (e.g., SLMB and LCP-MNP).

Expanded Specified Low-Income Medicare Beneficiary or Qualified Individual (QI-1)

This is an MAA program for certain low-income individuals who are also eligible for Medicare. Under this program MAA pays Medicare Part B premiums. Clients must meet income levels (120-135% FPL) and they **cannot be dual-eligible**.

Medicare Managed Care (Medicare Part C)

States have the option to pay managed care premiums for clients who are eligible for QMB and enroll in a Medicare-approved managed care plan. While states are not required to pay managed care premiums, they **are required** to pay managed care copayments for QMB clients up to Medicare's or Medicaid's allowable copayment (whichever is less).

TAKE CHARGE [Refer to Chapter 388-532 WAC]

TAKE CHARGE is a federal/state funded five-year family planning waiver program. The purpose of the TAKE CHARGE program is to make family planning services available to men and women with incomes at or below 200% of the federal poverty level.

Eligible persons receive pre-pregnancy family planning services to help them plan if or when to have children, and the timing and spacing of pregnancies.

Any medical service provided under the TAKE CHARGE program must be:

- Performed in relation to a primary focus and diagnosis of family planning; and

- Be medically necessary for the client to safely, effectively, and successfully use, or continue to use, the client's chosen contraceptive method.

A provider must be approved by MAA as a TAKE CHARGE provider to receive reimbursement for services provided to a TAKE CHARGE client unless the provider is a pharmacist, laboratory, or ancillary service provider *and the services are directly related to family planning*.

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